Bereavement

Margaret Stroebe, Utrecht University, Utrecht, The Netherlands
Henk Schut, Utrecht University, Utrecht, The Netherlands
Kathrin Boerner, Jewish Home Lifecare, New York, NY, USA

Abstract

The article outlines and reflects on the current state of scientific knowledge of bereavement. Bereavement reactions and associated health consequences are described, and the factors influencing vulnerability and resilience are summarized. We explore ways of coping and links to (mal)adjustment. We outline the current understanding of complicated grief and the effectiveness of psychological interventions. Theoretical developments, particularly those relating to grief complications, are considered. The bereavement research area is rapidly growing and evolving. Many firmly held views have been put to test and sometimes discarded. Therefore, throughout the article, we try to pinpoint key, sometimes controversial, issues and identify directions for future research.

Bereavement, Grief, and Mourning

The Latin derivations of the three closely related basic terms bereavement, grief, and mourning help pinpoint the overlap and differences between them, in addition to suggesting continuity in usage across the centuries. The term 'bereavement' comes from the Latin word *rumpere* (to break, to carry, or tear away). It refers to the objective situation of a person who has recently suffered the loss of a significant person through death. Some types of bereavement such as the loss of a close family member (child, spouse, or parent) have received more scientific attention than others (siblings, grandparents/children). There is room for expansion of research on other meaningful relationships too, including those that sometimes involve secrecy and private suffering (e.g., abortions, death of an ex-marital partner).

'Grief' is derived from the Latin word *gravare* (to weigh down). It refers to the emotional experience of psychological, cognitive/behavioral, social, and physiological reactions to one's loss; it is considered to be a complex emotional syndrome (see Table 1), and it is often regarded as the price we pay for love (thus linking the phenomenon to bonding and attachment to others; see Parkes, 2006). However, it is important to note that not all of these reactions are evident in any particular case and that considerable variation may occur across time and place.

'Mourning' is derived from the Latin word *memor* (mindful). It denotes actions and manners expressive of grief that are shaped by social and cultural practices and expectations that can differ greatly (e.g., the funeral as celebration of life vs as expression of pain; wearing of white vs black to funerals; spreading vs keeping of ashes; an open vs closed casket; removing vs cultivating reminders in one's living context). More research is needed to examine precisely how mourning customs (such as the rituals illustrated above) impact on grief (and vice versa).

The Impact of Bereavement

Although bereavement is associated with detrimental health consequences, it is important to emphasize that it is a normal, natural human experience, one that most people manage to come to terms with over the course of time and without the aid of professional intervention for their grief reactions. Indeed, it is a life event that, sooner or later, affects nearly everyone. Although comparatively rare in childhood, among children

Table 1 Reactions to bereavement

Affective	Depression, despair, dejection, distress
	Anxiety, fears, dreads
	Guilt, self-blame, self-accusation
	Anger, hostility, irritability
	Loneliness
	Yearning, longing, pining
	Shock, numbness
Cognitive	Preoccupation with thoughts of deceased, intrusive ruminations
	Sense of presence of deceased
	Suppression, denial
	Lowered self-esteem
	Self-reproach
	Helplessness, hopelessness
	Suicidal ideation
	Sense of unreality
	Memory, concentration problems
	Meaning making efforts
Behavioral	Agitation, tenseness, restlessness
	Fatigue, exhaustion
	Overactivity
	Searching
	Weeping, sobbing, crying
	Social withdrawal
Physiological–somatic	Loss of appetite
	Sleep disturbances
	Energy loss, exhaustion
	Somatic complaints
	Physical complaints similar to deceased
Immunologic and endocrine changes	Susceptibility to illness, disease, mortality

Adapted from Stroebe, M., Schut, H., Stroebe, W., 2007. Health consequences of bereavement: a review. The Lancet 370, 1960–1973.

below 18 years, approximately 3–4% can be expected to experience the death of a parent (in Western societies). By contrast, among elderly populations, approximately 45% of women and 15% of men over 65 years can expect to become widowed.

Bereavement is associated with a period of intense suffering for many people and with an increased risk of suffering mental and physical health problems. Adjustment is not confined to the calendar year that is commonly talked of as the expected duration of intense grief; sometimes it can take years. For the most part, researchers have abandoned the use of the word 'recovery' to describe the course of adaptation, acknowledging the experience of many bereaved persons that "one does not get over it, in time one gets used to it." There are substantial variations between individuals and across cultures not only in duration, but also in intensity of reactions. Some people show great resilience in response to loss. For others, typically a minority of bereaved persons, health consequences are extreme and lasting.

Examination of Phenomena and Manifestations Associated with Bereavement

Many questions have arisen and been given scientific attention regarding the links between bereavement and ill-health, for example: Is grief a disease? When might grief make you ill? Some persons develop nongrief-related mental and/or physical health difficulties, and some succumb to complications in the grieving process itself: Who suffers from what and why? Why do some have extreme and lasting effects, while others do not? We begin by addressing the most extreme health consequence, frequently posed as the question: Is there such a phenomenon as the 'broken heart'? Is it myth or reality?

The Mortality of Bereavement

There is considerable evidence that bereavement is associated with an increased risk of mortality from many causes, including suicide. Well-controlled studies now support the conclusion that the heightened risk of dying is attributable in large part to the so-called 'broken heart' phenomenon, if we understand this to imply psychological distress due to the loss, such as loneliness, and secondary consequences of it, such as changes in social ties, living arrangements, eating habits, and economic support. While most research has focused on heightened risk among widows and widowers, recently, it has extended to systematic investigation of mortality following the death of a child. For example, Espinosa and Evans (2013) reported increased risk of mothers dying after their child's death, with indications that the excess risk was concentrated in the first 2 years of bereavement. However, while the myth of the broken heart seems to be confirmed, it is important to emphasize that the investigations also show that in terms of absolute numbers, few people can be expected to succumb to this drastic outcome of losing a loved person; it is a rare occurrence.

The Range of Physical and Psychological Health Outcomes

Given the variety of reactions covered in **Table 1**, it is perhaps not surprising that bereavement is associated with a wide range of physical and psychological ailments and illnesses. Physical health problems are more frequently found among the bereaved than among matched nonbereaved control persons. The former also have higher rates of disability, medication use, and hospitalization than their nonbereaved counterparts. Widowed people consult with their physicians more often, most likely due to symptoms of anxiety and tension, but results of research also suggest that many with intense grief fail to seek medical help when they need to.

Studies have also confirmed elevated rates of psychological symptoms and ill-health, for example, of suicidal ideation, loneliness, insomnia, anxiety, depression, somatic symptoms, and social dysfunction. For a few people, depression or anxiety can reach levels that are of clinical importance. To indicate prevalence: According to some estimates, 25–45% of bereaved people have mild levels of depressive symptoms, while 10–20% reach clinical levels (Stroebe et al., 2007). In some cases, particularly following horrific death circumstances, the bereaved may develop posttraumatic stress disorder.

Recent research has attested to the need for differentiation regarding the range of health consequences. For example, in the past, a generic depression measure was frequently used instead of a specific grief one as an index of the impact of bereavement on mental health. Now it is recognized that grief and depression may, for example, represent distinct, though related, clusters of reactions to bereavement. They may be associated with different risk factors and difficulties and need separate investigation. Nevertheless, similarities have been emphasized. In an influential review, Zisook and Kendler (2007) concluded "The prevailing evidence more strongly supports similarities than differences between Bereavement Related Depression and Major Depression" (p. 779). Another issue concerns the scope of reactions from the typically negative ones listed, to more positive aspects. To illustrate, it is still a matter for consideration where such positive phenomena as personal growth fit in, since research on traumatic losses (particularly) has expanded the understanding of people's remarkable, not uncommon, resilience to enormous losses.

In some cases, the grieving process itself can become disturbed or complicated. Complicated grief (CG) has been variously defined, but most theorists understand it as a form of grief characterized by persistent, intense longing and yearning for the deceased (separation distress), intrusive thoughts or images, emotional numbness, anger or guilt related to the loss, a sense of emptiness, and reactivity in response to cues. At the same time, persons with CG often avoid people and places they associate with the loss, because of the intense distress those reminders evoke. Thus, CG tends to involve the oscillation between anxious preoccupation with and an avoidance of memories of the deceased. In addition, complicated grievers commonly have difficulty in redefining themselves (Mancini and Bonanno, 2006), and often experience difficulties in forming satisfying new relationships or engaging in potentially rewarding activities. The scenario of an initially absent grief reaction followed by a delayed response also seems possible, although empirical evidence on this phenomenon is scarce.

Estimates of the occurrence of CG vary widely, with some reporting 9% of a bereaved adult population and others 20%. In a study of parents who had lost a child through suicide or accident 18 months previously, Dyregrov et al. (2003) reported that as many as 78% scored above a suggested cut-off level on criteria for CG reactions – raising the question whether this

cut-off point is a good marker of CG or whether the norm scores for parents need to be reset (intense grief may not necessarily reflect 'complications').

In recent years, conceptualization and understanding of CG have been strongly channeled by the new Diagnostic and Statistical Manual of Psychiatric Disorders (DSM-5) of the American Psychiatric Association. We return to this below.

Risk and Protective Factors

The term 'risk factor' signifies the situational, intrapersonal, and interpersonal characteristics associated with increased vulnerability associated with the range of bereavement outcomes. Protective factors are those that promote resilience and lower the risk of adverse health consequences.

The situation and circumstances of death contribute to adjustment in complex ways. For example, the broader circumstances of death, including the cause and caregiver strain, must be taken into account. Also, combinations of situational factors (with other types, such as personality factors) can jointly account for the impact on adjustment. While some conclude that sudden unexpected death leads to worse bereavement consequences, others have found that caring for a terminally ill spouse can increase difficulties subsequent to death. Characteristics of the bereaved person or of the predeath relationship with the deceased also play a part. For example, research on attachment has strongly suggested that the quality and nature of the lost relationship is critical to outcome. Childhood loss of a parent has various long-term effects, but importantly, evidence suggests that the adequacy of the remaining parental care after the death of one parent and the resilience of the child him/herself are more powerful predictors of later adjustment than the loss of the parent per se.

Regarding interpersonal factors, a lot has been written over the years about the importance of social support; yet this has now been identified as a general risk factor, i.e., one that affects the health and well-being of nonbereaved to the same extent as bereaved persons. This suggests that others cannot easily take the place of the deceased, or make up for the loneliness following the death. More recently, finer-grained interpersonal processes have been researched and uniquely, intergenerational relationships were subjected to closer inspection. Carr and Boerner (2013) examined the extent to which adaptation to late-life widowhood was not only conditional upon qualities of the late marriage (positive and negative interactions, dependence), but also with parent–child relations in terms of support, criticism, and dependence. Importantly, it was found that widowed persons report significantly less criticism from and more dependence upon children than married controls. Furthermore, effects were conditional upon characteristics of the late marriage: among the bereaved, marital warmth is associated with high levels of support from children post-loss, whereas marital strains were associated with less emotional support from and dependence on children. Widow(er)s who were highly dependent on their late spouse reported lower levels of criticism from children. The importance of including interpersonal variables in risk factor research becomes evident. This extends to interpersonal processes in coping, which have been largely neglected.

Ways of going about dealing with bereavement, referred to as coping strategies or processes (including the interpersonal aspects just mentioned), can impede or facilitate adjustment, and as such can be considered risk factors. Indeed, and unlike many other risk factors, coping is a particularly important factor, because it can potentially be changed (e.g., amenable to interventions). The concept covers many dimensions. Doing one's 'grief work,' for example, used to be considered focal in coming to terms with loss, but more recent research has shown that people who do not work through their grief frequently recover as well as those who do. It was also widely believed that adaptive grieving involved 'letting go' of the deceased. Nevertheless, research over the last decade has shown a potentially healthy role of 'continuing bonds,' although the conditions under which continuing bonds are helpful or not still need to be established. Continuing bonds can reflect a lack of acceptance of the death of the loved one and an effort to maintain a concrete tie, rather than a more internalized, symbolic connection reflecting relinquishment and acceptance of the physical absence of the deceased. There are also considerable cultural differences in their meaning and influence.

So what additional directions should risk factor research take? Many potential risk factors have been underresearched, which is critical, particularly because it creates difficulties for scientists to develop valid screening instruments for use by practitioners. In this respect, studies of multiple risk factors and the interaction between such factors is advisable, rather than focusing (as in earlier studies) on single factors. It is important to establish the relative and the joint impact of risk factors. Finer-grained examinations of maladaptive (interpersonal) coping processes is another important approach that is already gaining momentum, as is the study of positive and negative cognitions and the regulation of emotion in grieving. Theory-guided research along these lines is essential. Finally, further investigation of the ways that risk factors relate to the different health outcomes described above is in order: Why does one bereaved person suffer complications in the grieving process, while another falls physically ill?

CG: Intervention and Diagnosis

We have already indicated that, for a minority of bereaved persons, grieving can take a difficult course, perhaps best summarized as a 'derailing' of the normal, if painful, process of adapting to the loss of a significant person. Given that there are complications, research also needs to address questions about the advisability and effectiveness of intervention. Linked to this are questions about the mental health status of bereaved persons who encounter difficulties in coping with their loss: should these bereaved persons be diagnosed with a mental illness?

Intervention Efficacy

Should intervention be recommended and if so, who benefits from it? More specific research questions include establishing the relative effectiveness of different types of intervention and exploring which type is effective for a particular mental and/or physical health difficulty. In fact, most research has investigated psychological, not medical or pharmacological, interventions, so we focus on the former type of treatment. It is also important

to note that adequate scientific investigation involves the use of randomized control trials (RCTs) for prevention or treatment. To establish efficacy, it is not enough to demonstrate that bereaved persons are satisfied with an intervention program: it needs to be shown that bereaved persons who are assigned to an intervention condition adjust to their loss relatively better than those not receiving treatment.

An approach that has frequently been adopted by bereavement researchers to try to establish who in general benefits from intervention has been to divide the programs into primary, secondary, and tertiary interventions. Primary interventions are those in which (professional) help is available to all bereaved persons, irrespective of whether intervention is indicated. Secondary interventions are designed for those who, through screening or assessment, can be regarded as more vulnerable to the adverse consequences of bereavement. Tertiary interventions refer to programs that provide therapy for CG, grief-related depression, or posttraumatic disorders, which are usually evident longer after bereavement (since pathological processes usually take longer to develop). Conclusions reached have been reasonably unanimous: there is little evidence that all bereaved people will benefit from counseling or therapy. Primary prevention can, however, be helpful when the initiative to get help is left to the bereaved person (indicating need). Secondary preventive interventions for risk groups seem to be an important provision, but as noted above, improvement in risk factor assessment is essential both for better and lasting results of interventions and for the adequate assessment of efficacy.

With regard to tertiary interventions, a wide variety of treatments for grief complications, now including remote modality ones, are available. Systematic comparisons of the relative effectiveness of different therapeutic approaches are still needed to understand what is most effective for whom, but there is evidence that tertiary interventions in general are effective. Wittouck et al. (2013) have reviewed studies investigating the short- and long-term effects of both preventive and treatment interventions specifically for CG. Results of their systematic analyses of the pattern of results of the available RCTs indicate that treatment interventions can effectively reduce CG symptoms. This indication of the efficacy of professional treatment for CG brings us to the related question about the diagnostic status of CG.

Diagnostic Status

Are (severe) complications associated with grief to be considered a mental disorder included in manuals of mental disorders? There has been considerable discussion, and opinions vary greatly regarding the definition and diagnosis of grief complications (cf Stroebe et al., 2013). In the new edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; APA, 2013), CG, termed persistent complex bereavement disorder (PCBD), is not listed among established disorders but among conditions requiring further research investigation. (While the focus was recently on the DSM-5 (particularly in the U.S.A.), the ICD-11 is currently being drafted and is due for publication in 2015. The ICD system is a core instrument of the WHO, which is in its constitution and is ratified by all the WHO member states.) A further change in the DSM-5 since the previous edition has been the removal of the exclusion of bereavement in the first 2 months from the criteria for the diagnosis of major depressive disorder (MDD). Although the article dictates caution in making a diagnosis of MDD for a bereaved person, concerns remain that in practice, the removal of this exclusion criterion may lead to overdiagnosis of recently bereaved persons as having MDD; early on, they may very well reach the levels of symptomatology defined in the diagnostic criteria for MDD.

An additional concern, given the DSM-5 developments outlined above, is the potential neglect of subtypes of CG, described in classic sources (particularly the clinical literature). Chronic grief, which is similar to PCBD (and as such covered in the DSM-5 to some extent), is characterized by the long-lasting presence of symptoms associated with intense grief. Delayed or inhibited grief have been taken to occur in cases where there is little or no sign of grieving early on in bereavement, but rather, at a later time (clearly, pathology is not always indicated by early lack of symptoms). Absent grief has been understood to be problematic if the person manifests other symptoms, atypical of grief. However, the existence and impact of delayed, inhibited, and absent grief subtypes is currently debated; more empirical research is needed.

Theoretical Understanding

Theoretical approaches to bereavement provide explanations for phenomena and manifestations of grief and grieving. For example, some provide insights into mal/adaptive coping mechanisms, which are potentially useful for guiding research, and ultimately, for applied use in helping the bereaved. Theories vary widely with regard to basic principles, levels of analysis, and degree of specificity. They also range from application to bereavement of general psychological theories such as psychoanalytic and attachment theories or theories of loss and trauma, to bereavement-specific models of coping.

Much theorizing in the bereavement field has been influenced by Freud's (1917) paper 'Mourning and Melancholia.' According to this psychoanalytic approach, when a loved one dies, the bereaved person is faced with the struggle to sever ties and detach the energy invested in the deceased person. The psychological function of grief is to free the person from the ties to the deceased, achieving a gradual detachment by means of the process of grief work. Grief work remained a central concept not only in subsequent theories but also in principles of counseling and therapy. It denotes a cognitive process of going over events that occurred before and at the time of death and focusing on memories and working toward detachment from the deceased. According to Freud, a major cause of pathological grief was the existence of ambivalence in the relationship with the deceased preventing the normal transfer of libido (energy) from that person to a new object.

The notion of grief work has been one of the most persistent features of psychoanalytic theory to influence subsequent research and thinking about coping with bereavement. While its theoretical interpretation is different, it has been incorporated in the major contribution of Bowlby, in his attachment theory (e.g., Bowlby, 1980). Bowlby focused on the biological rather than the psychological origins of grief. According to his

approach, the biological function is to regain proximity to the attachment figure, separation from which has caused anxiety. In the case of permanent loss, regaining proximity is not possible; the response is dysfunctional because reunion cannot be achieved. But an active working through of the loss still needs to be done, as it is an essential part of grief and grieving. The focus on working through grief led Bowlby to formulate phases or stages of grieving (shock, numbness and denial, yearning and protest, despair, and gradual recovery). However, there has been a move away from a phased approach, particularly in view of the evidence that grief and grieving do not follow a predictable, sequential order from initial high distress to return to normal (although it is important to remember that the phases were initially conceptualized as descriptive, i.e., indicating regularities, rather than being prescriptive). One major shift was brought about by Worden's identification of tasks rather than phases of grief (e.g., Worden, 2009), in terms of acceptance of the reality of loss, processing the pain, adjusting to a world without the deceased, and retaining connection with the deceased while embarking on a new life. Worden's tasks have provided clinicians with a 'tool' to help clients work through their grief. A further major development has been Bonanno and colleagues' (e.g., Bonanno et al., 2008) identification of trajectories of grief. Their research showed that there are qualitatively distinct pathways across the months following the loss of a loved one, supporting the conclusion that the grieving process cannot be well described in terms of a single set of stages or tasks. Bonanno's research suggested that resilience is actually common and that delayed grief is rare.

In other respects, attachment theory has also remained enormously influential in contemporary bereavement research. Early childhood experiences with attachment figures are still considered critical. These experiences are understood in terms of the development of either secure or insecure bonding with the caregiver, and this emerging style of attachment has a lasting influence on later relationships. To illustrate, frequent separation from attachment figures in childhood can lead to anxious attachment in later relationships, which is associated with chronic grief. Mikulincer and Shaver (e.g., 2013) have conducted sophisticated empirical research, confirming the importance of attachment security in the prediction of adjustment to bereavement and providing a fine-grained understanding of many associated phenomena.

Diverse trauma and stress theories have influenced the understanding of the phenomena and manifestations of bereavement. One major line of work is represented by the work of Horowitz and colleagues (e.g., Horowitz, 1986), applicable to traumatic events in general. A basic assumption of this approach is that stressful life events (SLEs) play an important role in the etiology of various somatic and mental disorders. A further line of research derived from the related field of trauma was that of Janoff-Bulman (1992), particularly through identification of shattered beliefs, which need to be rebuilt. This has been expanded to the study of 'meaning making' particularly by Niemeyer and collaborators (e.g., Neimeyer, 2001), giving centrality to the need for 'making sense' and 'finding meaning' after the loss of a loved person. A basic idea is that the reconstruction of meaning about the self and the world is critical to adjustment. Difficulties in establishing the role of meaning making in adjustment remain (e.g., studies have not always succeeded in separating the process from the outcome, beliefs from adjustment, or establishing the direction of causality among these factors). Others have distinguished two components of meaning-making. Davis et al. (1998) identified two distinct processes, making sense of the loss and finding benefit, which entail distinguishable psychological concerns for the bereaved person, with, for example, the former diminishing in importance in time, while the latter growing stronger as time goes on.

Stress theorizing received independent impetus through the work of Lazarus and Folkman (1984), who provided detailed analyses of coping processes, through which SLEs may precipitate poor physical or mental health outcomes. A major premise of their cognitive stress theory is that the intensity of stress created by an SLE depends on the extent to which the perceived demands of the situation tax or exceed an individual's coping resources, given that failure to cope leads to negative outcomes. Recently, research has identified neurophysiological mechanisms linking stress with various detrimental consequences to the immune, gastrointestinal, and cardiovascular systems (O'Connor, 2013). Folkman (2001) applied cognitive stress theory specifically to the stressor of bereavement, significantly extending the perspective to include positive emotions/appraisals as a component in coping with bereavement. Drawing partly on this theoretical approach, Stroebe and Schut (1999) developed their dual process model (DPM), a bereavement-specific coping model, to try to capture the complexity, diversity, or idiosyncratic nature of grieving. They postulated two types of stressor, the first called loss orientation, which relates to the deceased person (e.g., ruminating about the death), and the second restoration orientation, which has to do with secondary stressors that come about indirectly but as a consequence of the death (e.g., dealing with new financial concerns). Rather than assuming phases or tasks, the DPM includes an emotion regulation process, labeled oscillation. Adaptive coping entails oscillation between the two types of stressor and 'time out,' given the necessity to rest from the arduous process of dealing with the loss.

Conclusions

Loss of a loved one can cause deep suffering and the risk of mental and physical health detriments, but it is important to remember that grief is a normal, natural response to bereavement. Most reactions are not complicated and for most persons, family and friends, religious and community groups, and various societal resources will provide the necessary support. Professional psychological intervention is generally neither justified nor effective for uncomplicated forms of grief.

Although advancements across all the areas of research reviewed above have been evident in recent years, improvement in the design of research projects is often indicated, for example, in the design of intervention programs and for strict assessment of their relative effectiveness, following evidence-based criteria. Furthermore, gaps in knowledge still remain. So what directions should future research take? Both micro- and macrolevel extensions can usefully be pursued. At microlevel, one line of research that is currently expanding is fine-grained cognitive/emotional (regulatory) process analyses,

including physiological measurement. Laboratory techniques are beginning to answer questions about distinctions between adaptive grief work and maladaptive rumination and to link these to confrontation versus avoidance processes.

At macrolevel, more research is needed that not only focuses on bereaved individuals, but also on families, organizations, and cultural groups, to investigate broader changes that may be triggered by a loss. Inclusion of underacknowledged, disenfranchised groups within this wider scope seems essential and many examples come to mind, such as those with learning difficulties, expartners, nursing home and home care staff's grief for their patients. Finally, much is still to be learned about – and to be gained scientifically – by extending consideration to losses without physical death, such as organ donation, euthanasia, dementia, or irreversible coma.

See also: Co-morbidity of Mental and Physical Conditions; Health and Illness: Mental Representations in Different Cultures; Mental Health; Religion and Health: Clinical Considerations and Applications; Social Support and Recovery from Disease and Medical Procedures.

Bibliography

American Psychiatric Association, 2013. Diagnostic and Statistical Manual of Mental Disorders, fifth ed. American Psychiatric Association, Washington, DC.

Bonanno, G., Boerner, K., Wortman, C., 2008. Trajectories of grieving. In: Stroebe, M.S., Hansson, R.O., Schut, H., Stroebe, W. (Eds.), Handbook of Bereavement Research and Practice: Advances in Theory and Intervention. American Psychological Association, Washington, DC, pp. 287–307.

Bowlby, J., 1980. Attachment and loss. In: Loss: Sadness and Depression, vol. 3. Hogarth, London.

Carr, D., Boerner, K., 2013. The impact of spousal loss on parent-child relations in later life: are effects contingent upon the quality of the late marriage? In: Stroebe, M., Schut, H., Boerner, K. (Eds.), Bereavement: A Family Perspective. Family Science, 4, 37–49 (Special Issue).

Davis, C., Nolen-Hoeksema, S., Larson, J., 1998. Making sense of loss and benefitting from the experience: two construals of meaning. Journal of Personality and Social Psychology 75, 561–574.

Dyregrov, K., Nordanger, D., Dyregrov, A., 2003. Predictors of psychosocial distress after suicide, SIDS and accidents. Death Studies 27, 143–165.

Espinosa, J., Evans, W., 2013. Maternal bereavement: the heightened mortality of mothers after the death of a child. Economics and Human Biology 11, 371–381.

Folkman, S., 2001. Revised coping theory and the process of bereavement. In: Stroebe, M., Hansson, R.O., Stroebe, W., Schut, H. (Eds.), Handbook of Bereavement Research: Consequences, Coping, and Care. American Psychological Association Press, Washington, DC, pp. 563–584.

Freud, S., 1917/1957. Mourning and melancholia. In: Strachey, J. (Ed.), Standard Edition of the Complete Work of Sigmund Freud. Hogarth Press, London, pp. 240–263.

Horowitz, M., 1986. Stress Response Syndromes. Aronson, Northvale, NJ.

Janoff-Bulman, R., 1992. Shattered Assumptions: Towards a New Psychology of Trauma. Free Press, New York.

Lazarus, R., Folkman, S., 1984. Stress, Appraisal, and Coping. Springer, New York.

Mancini, A., Bonanno, G., 2006. Resilience in the face of potential trauma: clinical practices and illustrations. Journal of Clinical Psychology: In Session 62, 971–985.

Mikulincer, M., Shaver, P., 2013. Attachment insecurities and disordered patterns of grief. In: Stroebe, M., Schut, H., van den Bout, J. (Eds.), Complicated Grief: Scientific Foundations for Health Care Professionals. Routledge, London, pp. 190–203.

Neimeyer, R., 2001. Meaning Reconstruction and the Experience of Loss. American Psychological Association Press, Washington, DC.

O'Connor, M.-F., 2013. Physiological mechanisms and the neurobiology of complicated grief. In: Stroebe, M., Schut, H., van den Bout, J. (Eds.), Complicated Grief: Scientific Foundations for Health Care Professionals. Routledge, London, pp. 204–218.

Parkes, C.M., 2006. Love and Loss: The Roots of Grief and Its Complications. Routledge, London.

Stroebe, M., Schut, H., 1999. The dual process model of coping with bereavement: rationale and description. Death Studies 23, 197–224.

Stroebe, M., Schut, H., Stroebe, W., 2007. Health consequences of bereavement: a review. The Lancet 370, 1960–1973.

Stroebe, M., Schut, H., van den Bout, J. (Eds.), 2013. Complicated Grief: Scientific Foundations for Health Care Professionals. Routledge, London.

Wittouck, C., van Autreve, S., de Jaegere, E., Portzky, G., van Heeringen, K., 2013. The prevention and treatment of complicated grief: a meta-analysis. Clinical Psychology Review 31, 69–78.

Worden, J., 2009. Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner. Springer, New York.

Zisook, S., Kendler, K., 2007. Is bereavement-related depression different than non-bereavement-related depression? Psychological Medicine 37, 779–794.